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ABSTRACT

This monograph, the second in a series of five, provides information for trainers on interdisciplinary team training and humanistic patient care in hospices. Designed to help outside trainers who may be invited by a hospice to conduct its training, the materials help instructors to understand the nature of hospices, to determine whether or not the hospice and the trainer match sufficiently for the training to be effective, and to recommend the appropriate staff members to be trained. The first chapter outlines the purpose of the guide and defines terms pertaining to interdisciplinary teams and humanistic care. Covered next are the hospice concept, the United States hospice organization, hospice staffing and staff characteristics, and unique features of hospices. Alternatives concerning the structure and numbers of participants in training programs are presented. Addressed in a chapter on the roles of hospice trainers are hospice prerequisites, trainer motivations, the role of the interdisciplinary and the humanistic patient-care trainer, the role of the trainer as a group leader, and trainer self-assessment. Various suggestions from hospice training experience are offered. The final chapter is a guide to later monographs. Appended are the tables of contents of the five monographs and a list of contributors to the series. (MN)

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THE ELM INSTITUTE

GUIDE FOR TRAINERS

Monograph 2 in a Series:

INTERDISCIPLINARY TEAM TRAINING AND

HUMANISTIC PATIENT CARE

FOR HOSPICES

September 1981

Developed under
Health Resources Administration
Contract No. 232-79-0082
U.S. Department of Health and Human Services
Public Health Service

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GUIDE FOR TRAINERS

Monograph 2

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Developed under
Health Resources Administration
Contract No. 232-79-0082
U.S. Department of Health and Human Services
Public Health Service

An ELM Institute Project:

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MONOGRAPH 2

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FOREWORD

The ELM Institute is a not for profit corporation, founded to conduct research and education in established and emerging areas of health care delivery and policy. From the outset, one of the Institute's three major areas of interest has been terminal care, the others being cancer care and long term care of the impaired elderly.

While terminal care must function in the established health care delivery arena, its goals are substantially different. Instead of cure and rehabilitation, it acknowledges death and seeks to assure physical, spiritual, emotional and social comfort. We reasoned that this type of dichotomy would present organizational, structural, economic, and personnel difficulties as these two approaches were merged. These issues and their management are primary areas of interest to Institute staff.

For these reasons the Institute was pleased to receive the DHHS award to study the interdisciplinary team training and humanistic care training needs of terminal care programs. I believe the results contained in these volumes confirm our mutual judgment that alternative modes of health care delivery require unique staff interactions and support mechanisms in order to survive and meld with the current care system. Further, I believe you will find that the concepts utilized in this model for training and team development have broader programmatic applications than terminal care.

The Institute will continue to test and refine the model, and is willing to work with those programs who require specialized expertise or who face unique circumstances. In many other cases, it is our hope that these modules will provide sufficient information to an informed and experienced process consultant.

From the Institute's perspective, we intend to continue similiar research and development projects in health care delivery and in policy formulation. We are pleased to have had an excellent opportunity to further our investigations and to work with an excellent group of advisors and collaborators.

Lee E. Mortenson
President
ELM Institute
Rockville, Maryland
August, 1981

PREFACE

Purpose of the Series

The purpose of this series of monographs is to assist hospices in improving their quality of care, through enabling them to improve their ability to meet the needs of their patients and families. Objectives include: improving the functioning of the interdisciplinary team, integrating the patient and family into the team, ensuring the appropriate utilization of professional services, and improving staff awareness and capability of providing humanistic patient care. These objectives may be attained through a training program for hospice staff described in the monographs.

The goals and objectives of the training program relate directly to those of hospices. Both direct attention to the whole person - patient, family member, or staff member - individually and as a group member. Both attempt to integrate the physical, psychosocial and spiritual approaches to care. Both combine scientific knowledge, skills, affective awareness, and interdependent coordination of activity to achieve an orientation to comfort and growth for all those involved. Hospices, having already made significant progress toward their goals, can expect the training program to enable them to approach these goals more quickly, more comfortably, and more effectively.

Hospice staff members need to be highly skilled in both the technical and the humanistic aspects of health care. These monographs acknowledge the need for high quality professional skill on the part of all staff members but do not address it. Training information in this aspect is assumed to be already in place. This series of monographs was developed to fill an acknowledged gap in training information for hospices, that is, training information in improving team function and humanistic care provision.

The monographs provide a significant contribution to these hospice activities. They provide factual information, approaches, and methods for qualified trainers to utilize their existing knowledge and skills successfully in the unique environment of the North American hospice. The series is intended primarily for the use of trainers assisting hospices, and not as a self-

help guide for hospices; however, all or parts of the series may be a helpful resource not only to hospices and hospice trainers but also to others concerned with the interdisciplinary and humanistic qualities of hospice care.

These monographs are working documents. The information they provide has been developed by trainers who are leaders in the field, tested in two demonstration hospices, and then modified on the basis of these tests. The developers anticipate that additions and variations will be appropriate over time and through continuing use of the document.*

Review of the Series

This series of five monographs was written by the ELM Institute under the general title: Interdisciplinary Team Training and Humanistic Patient Care for Hospices. The monographs, outlined below, address the following topics:

Monograph 1: Guide for Hospices
Monograph 2: Guide for Trainers
Monograph 3: Training Program Design
Monograph 4: Interdisciplinary Team Training: Content and Methodology
Monograph 5: Humanistic Patient Care Training: Content and Methodology

Monograph 1, Guide for Hospices, is directed to hospice administrators. It may, however, be of interest to trainers and others. It describes teams, team function and the provision of humanistic patient care, and assists hospices to determine whether or not they have reached the state of development needed for this training. It identifies the objectives of the training and the anticipated benefits to the hospice, as well as the role of the hospice administration in the training and its financial and other obligations. In particular, it assists hospices to recruit and select one or more qualified trainers from outside the hospice organization to conduct the training. It also supplies useful suggestions to hospices based on ELM's hospice training experience.

Monograph 2, Guide for Trainers, is directed to "outside" trainers who may be invited by a hospice to conduct its training, although

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* Reports of experiences with the monographs and any recommended additions or modifications to them would be welcomed by the developers - the ELM Institute, 11600 Nebel St., Rockville, Maryland, 20852 - for inclusion in future revised editions.

it may be of interest to others, as well. It is recommended that all trainers anticipating work in hospices read this monograph, regardless of their prior experience, in order to learn more about the unique features of a hospice and the implications of training in the hospice setting. The document provides background information about the hospice concept, models, components, standards, and staff characteristics. It also assists trainers to determine whether or not the hospice and the trainer match sufficiently well for the training to be successful, and to recommend the appropriate staff members to be trained. The role of the trainer is reviewed and suggestions from ELM's hospice training experience are offered.

Monograph 3, Training Program Design, is directed primarily to the trainer(s) who has contracted with the hospice to conduct the training. It will also be useful to hospices in working with the trainer in developing their programs. It may also be of value to others. The monograph provides a detailed statement of goals and objectives of the training, and describes the steps of the training design: orientation of staff, initial data collection, identification of issues specific to the hospice concerned, preparation of reports, feedback of the reports to the staff, confirmation and prioritization of issues, and joint staff/trainer selection, design and planning of a customized training program to address these issues. Again, examples from hospice training experience are reported.

Monograph 4, Interdisciplinary Team Training: Content and Methodology, is again directed to the trainer, although it may also be of interest to hospices and others. It contains the materials needed to conduct the training, and includes examples of issues and approaches to interdisciplinary team training in the hospice setting. It is not intended to limit the trainer but to assist by providing hospice information, outlines of successful training sessions, examples from hospice training experience, and relevant literature resources. It contains checklists and hints that may be useful to trainers, particularly in their first hospice training experiences. The monograph is divided into four sections, covering the major interdisciplinary team training categories: goals, roles, structure, and procedures.

Monograph 5, Humanistic Patient Care Training: Content and Methodology, provides trainers with information concerning humanistic patient care training in hospices and is similar in structure to that in Monograph 4. Again, although directed to the trainer, it may also contribute to understanding by hospices and others of the humanistic approach and what training in humanistic patient care entails. The document provides examples from hospice experience in humanistic values and orientations, in issues relevant to training, and in humanistic training in hospices. There are sections on background information, checklists and hints for trainers, and outlines of successful training sessions. Pertinent references to the literature are included. The monograph addresses the definition of humanistic patient care and the topics: psychosocial variables in working with dying patients; patient and family needs, environment and

rights; patient/staff relationships, including listening and stress management techniques; staff/staff relationships and staff relationships with other health professionals, including listening and communication skills; and monitoring of humanistic patient care provision.

It is not essential for hospices or trainers to acquire the complete series. Each monograph was prepared to address a different audience and to be complete in itself. This approach however, necessitated the inclusion in more than one monograph of certain sections common to more than one audience or title. The reader of the entire series will be well aware of these repetitions.

Review of the Project

This series of monographs was developed by the ELM Institute under a two-year contract with Health Resources Administration, Department of Health and Human Services, entitled: "Assessment of Staffing Patterns and Development of Interdisciplinary Team Training and Humanistic Patient Care in Hospices". The contractor was the ELM Institute, with David J. English, D.B.A., its Executive Director, the project director and Dottie C. Wilson, its Hospice Group Director, the associate project director.

A Panel of Consultants was named to provide technical assistance and to assist in the development of a training program plan and an evaluation plan. Some members of the panel conducted hospice training sessions. An Ad Hoc Review Committee was named, representing major health care associations and approaches, to provide a broad perspective to the work undertaken and to assess its applicability to the health care system.

An analysis was performed of documents describing the organization and staffing patterns, including staff characteristics, in current U.S. hospices. The documents analyzed were the more than 250 applications by hospices to the Health Care Financing Administration for waivers of certain reimbursement regulations. This analysis, along with bibliographies and assessments of the anticipated impact of training on hospices, was published in July 1980 in a report entitled: An Assessment of the Existing Staffing Patterns and Personnel Required in a Hospice to Deliver Interdisciplinary Patient Care and the Problems Related to Delivering Humanistic Care to Hospice Patients.

ELM staff and Panel of Consultant members developed a training program plan, a statement of training goals and objectives, and, with the subcontractor, an evaluation plan. To test the plan, training was conducted in two demonstration hospices,

one an independent home care program and the other an inpatient and home care program within a hospital. The training was conducted by certain members of the panel of consultants with ELM coordination. Those trained included steering committees, a management team and patient care teams. The training was evaluated by the ELM Institute's subcontractor, Perry Cohen Associates, using both impact and process evaluation techniques.

Acknowledgements

The smooth conduct of the HRA contract and the significance of its results have been made possible by the availability and assistance of the HRA Project Officer, Mr. Thomas Aschenbrener. ELM appreciates very much his contribution to the success of the project and to the series of monographs.

All those who contributed to the prcject and to the series of monographs are listed in the Appendix to this volume. ELM extends sincere thanks to each of them, and in particular acknowledges the significant contributions of John A. Hackley, M.S.W., Mark S. Plovnick, Ph.D., Charles Seashore, Ph.D., and Terence F. VanOrshoven, Ph.D., to the development of the monographs.

The success of the training program demonstrations was in large part due to the enthusiasm, cooperation and support of the leadership of the two hospices concerned. Special thanks are due to Anne Kirschner Katterhagen, R.N., B.S.N., Executive Director of Hospice of Tacoma, Tacoma, Washington, and both Maryanne Fello, R.N., Director of Hospice Care, and Madalon Amenta, Dr.P.H., Director of Research and Education, Forbes Hospice, Pittsburgh, Pennsylvania, for their interest and assistance in the training demonstrations.

The ELM staff, including senior associates, research associates, and support staff, have been most helpful throughout the project and monograph preparation. We appreciate it.

David J. English, D.B.A., Project Director, and Dottie C. Wilson, Associate Project Director.

September 1981

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CHAPTER I. INTRODUCTION

A. Purpose of this Guide

This Guide for Trainers is intended to assist trainers in assessing both their interest in working with hospices and their qualifications to conduct this training in hospices. Its purpose is to supplement the extensive knowledge and experience the trainer has already acquired with hospice-specific information. Although it may be of interest to others, it is directed primarily to those team and humanistic trainers who either have been invited by hospices or are considering offering themselves to hospices to conduct this training. As described in Monograph 1, Guide for Hospices, the training is intended to be conducted not by the hospices themselves but by one or more trainers outside the hospice who can provide an objective, facilitative role and who have specialized training and experience.

All potential hospice trainers are urged to read this monograph carefully and completely in order to relate their own skill, knowledge and experience to the hospice scene.

Guide for Trainers includes information about hospices for trainers unfamiliar with hospice, including the concept, models, standards, staff characteristics, and unique features. The role and prerequisites of the trainer, and, in particular, the trainer's self assessment, are discussed. The monograph describes some alternatives in training program structure and participation, and concludes with suggestions based on training experience in hospices. Since hospice trainers will be referring frequently to Monograph 3 and either or both Monographs 4 and 5, a guide to the use of these documents is appended.

The proposed training is described throughout this series of monographs as being in two sections: interdisciplinary team training and humanistic patient care training. Each of these again addresses a number of aspects. Interdisciplinary team training addresses: the organization and the environment in which teams perform their tasks, the internal functioning of the teams themselves, and the relationship of team function to both task performance and the organizational environment. Humanistic patient care training, too, is concerned with the communication and interpersonal relationships between team members and between the team and its broader organization, but emphasizes the performance of team or individual tasks. It, therefore, includes staff understanding of the needs, rights and interrelationships of patients and families, as well as staff/patient and staff/family communication.

Both interdisciplinary team training and humanistic patient care training address task performance and goal accomplishment in meeting patient and family needs, as well as the acquisition of knowledge, understanding, skills and techniques to this end. Clearly both are inexorably interrelated and interdependent, and need to be considered as parts of the same process.

This training may be conducted by one, two or more trainers, who are found to have the skills and motivation needed for all or parts of the training program. The number of trainers and the role of the trainer in each of the two sections of the training are described further in Chapter IV of this Monograph.

As a result of this training, hospices expect to see the growth of the team (or teams) as a more cohesive and efficient functioning unit which provides improved patient and family care. There is expected to be a better staff understanding and acceptance of the patient and family as part of the team, and as participants in the direction, provision, and evaluation of their care. An improvement in staff stress, staff turnover, and staff effectiveness may also be anticipated.

B. INTERDISCIPLINARY TEAM AND HUMANISTIC CARE DEFINITIONS

Meeting the needs of terminally ill patients and their families requires an interdisciplinary and humanistic approach to care. "Meeting needs" infers that the patients/families communicate their needs, directly or indirectly, and that the staff members understand the communication. Staff members also independently recognize patient and family needs and can help them to acknowledge unrecognized yet real needs. The staff then makes every effort to find approaches to meeting the needs.

The patient is recognized as a person with decision making, planning, care delivering and evaluating powers. The family is viewed in the same way. Both patient and family understand their rights and realize that they are in control. They also recognize that they are capable of personal growth through the dying experience. Humanistic patient care is this approach by staff to patients and families. It includes state-of-the-art professional physical care and psychosocial and spiritual support of patients and families as they maintain their independence and their preferred way of life and death.

As the needs of terminally ill patients and their families may be in multiple areas, multiple skills and disciplines must be utilized in any attempt to meet them. The approach, then, must be multidisciplinary. As these needs overlap for the patients and families, and as the solutions to some needs may conflict with solutions to other needs of the same patient and/or family, an interdisciplinary approach is needed. As no one person or profession can meet all the needs, and as no one person can successfully cope alone with the stresses inherent in this work, a team approach is indicated. The patient and family participate as team members. An interdisciplinary team, providing input into assessment, decision making, care and evaluation, with blurring of traditional roles and mutual information sharing and support, has been found to be a most effective approach to terminal care.

1. Interdisciplinary Team

Team activity is not confined to health care nor to any one specific structure. There are board member teams and management teams, as well as staff teams. Teams may have consistent membership or may have rotating members; teams may work together with frequent team meetings, or they may seldom meet face to face. They may be made up of members of one profession or discipline, or may include more than one profession or a mixture of professions and disciplines. An interdisciplinary team has been defined

by Ducanis and Golin* as "a functioning unit, composed of individuals with varied and specialized training, who coordinate their activities to provide services to a client or group of clients". Rubin, Plovnick and Fry** add that coordinating activities requires teamwork. "This need for coordination and working together is called 'interdependence'. Any job that cannot be done by just one person requires some degree of interdependence." (Hospice interdisciplinary teams are discussed at greater length in Monographs 1 and 3.) The Health Resources Administration has defined an interdisciplinary health team as follows:

> INTERDISCIPLINARY HEALTH TEAM is composed of three or more health professionals, including physicians and physician's assistance or nurses, who relate on an equal non-hierarchial basis to each other in the provision of health services to primary, secondary and tertiary care patients. Usually such teams have received didactic and experiential training concerning the roles of other health professionals, interpersonal communications, small group process, other organizational development concepts, and patient/provider relationships. The patient and the patient's family are considered members of the interdisciplinary health team, along with the physician and such staff as physician's assistants, nurses, aides, physical and occupational therapists, pharmacists, clergy, social workers, psychologists, administrators and volunteers as appropriate.***

2. Humanistic Care

The term humanistic patient care describes an activity that evades clear definition. In hospice, it has been defined by the humanistic training consultants of this project as a timely comfort-oriented focus for patient care and family care delivery. The term indicates an increased emphasis on the non-scientific elements of professional patient care (without reducing emphasis on the scientific elements).

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* Ducanis, A.J. and Golin, A.K., The Interdisciplinary Health Care Team, Germantown, Maryland, Aspen Systems Corporation, 1979, page 3.

** Rubin, I.M., Plovnick, M.S., and Fry, R.E., Improving the Coordination of Care: A Program for Health Team Development, Cambridge, MA, Ballinger Publishing Co., 1975, page 3.

*** Adapted from: A Discursive Dictionary of Health Care, U.S. House of Representatives, Subcommittee on Health and Environment, 1976.

The Health Resources Administration has defined humanistic patient care by reference to a definition of humanistic medicine:

> HUMANISTIC MEDICINE is medical practice and culture which respects and incorporates the concepts that: the patient is more than his disease, the professional more than a scientifically trained mind using technical skills, both are whole human beings interacting in the healing effort, a person is more than his body, he is a unique, interdependent relationship of body, mind, emotions, culture and spirit; each person has the capacity to define and be increasingly responsible for himself, the professional seeks to assist the patient in taking and fulfilling his responsibility for himself; health and disease are not matters of the moment but have intricate past, present and future; disease, physical, emotional or spiritual pain and suffering, aging and death are meaningful events in an individual's life; and effective health care requires not just conventional skills but also effective development and use of human qualities such as intuition, inventiveness and sympathy.*

Since hospices are relatively new to the health care delivery system and since their development, staffing and purposes may differ from conventional health care, the information in the next chapter is intended to enable trainers to understand hospices more clearly.

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* Adapted from: A Discursive Dictionary of Health Care, U.S. House of Representatives, Subcommittee on Health and Environment, 1976.

CHAPTER II. HOSPICE DEVELOPMENT AND CHARACTERISTICS

A. Introduction

The concept of hospice is both new and very old. The name has been taken from the days of the crusades, when those ill, old or exhausted were cared for in hospices stationed along the crusade routes. Since that time many forms of care for the old and dying have existed, most frequently supported by religious orders.*

Less than twenty years ago, however, as a reaction to the increasing emphasis on technological medicine, institutionalization and denial of death, attention began to be focused on the deficiencies in the care of the terminally ill and dying. Two major influences - Elisabeth Kubler-Ross in the United States and Cicely Saunders in England - increased public awareness of not only the current inadequacies but also the new understanding and methods to make vast improvements in the quality of dying and death for most terminally ill people and those close to them. Dr. Saunders opened the first "hospice", in its present day meaning, near London, England, in 1967.

Since that time the study of dying, death and grief has "come out of the closet", and hospices have spread to many parts of the world, including the United States. The first hospice in this country - a home care program - opened in New Haven, Connecticut, in 1974.

Synonymous with the word "hospice" in its current meaning is "palliative care". This term is used by an increasing number of programs for a variety of reasons: language (the word hospice means a home for the poor elderly in French), disassociation from the early volunteer programs, etc. Palliative care centers or services, or palliative treatment programs have tended to be associated with hospitals. Other terms sometimes used for programs with this approach to care include: death and dying program, continuing care unit, center for living with the dying, and continuity of life program.

The information about hospices in this chapter is grouped under the following headings:

- The Hospice Concept: description, components, goals and objectives, standards, and a comparison of hospice and conventional care.

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* Stoddard, S., The Hospice Movement, A Better Way of Caring for the Dying, New York, Stein and Day, 1978. This book includes an interesting description of the early hospices and a discussion of the meaning of the words "hospice", "hospital", "host", and "hospitality".

- U.S. Hospice Organization Models: independent (freestanding) hospices and dependent (institution-based) hospices.

- Hospice staffing and Staff Characteristics: staff membership, staff-patient ratios, personnel policies, staff selection and characteristics, and staff stress.

- Unique Features of Hospices: quality of staff selection and training, team composition and roles, hospice size and model, medical community support and physician role, relationship with the health care system, and reimbursement.

With this background, trainers should be able to determine their own interest in working with hospices and also to evaluate a particular hospice in terms of the hospice movement in general.

B. The Hospice Concept

1. Description

The concept of hospice has developed out of this growing awareness of inadequate terminal care. Hospice is a specialized health care program, emphasizing the management of pain and other symptoms associated with terminal illness, while providing a caring environment for both the patient and the family.

Hospice acknowledges that dying is a human event, profoundly influenced by the background, lifestyle and temperament of the person dying. Humanistic patient care in hospice means the involvement of staff as persons relating directly to patients and families as persons. It requires, therefore, staff skills of communicating, trusting, acknowledging their own feelings and coping with the loss and pain of others. These skills can be taught and effective coping and support mechanisms can be developed.

Hospice emphasizes continuity of care in meeting the multiple needs of dying persons - physical, emotional, interpersonal, financial and spiritual. An interdisciplinary team approach to care, with the patient and family participating as team members, is a basic tenet of the hospice concept. Care of the family continues after the death.

2. Components

A full hospice program consists of four major components - all important for continuity of care and community support:

- Home care, when there is a primary care giver and the patient and family want the patient at home. The emphasis of hospice is on home care, frequently made possible only through the skill and support of hospice staff.

- Inpatient care, when symptoms cannot be controlled at home, when no arrangements can be made for a primary care giver in the home, or when respite care is needed for family or patient.

- Bereavement follow-up care, as long as needed by those most affected by the death.

- Education of the community, care givers, and care receivers in understanding the needs of the terminally ill and in hospice as a significant approach to meeting these needs.

Additional components in some hospices include: consultation team, day care and/or night care, and outpatient clinic.

Interdisciplinary teams providing humanistic patient care are vital to the success of home care, inpatient care, and bereavement follow-up care. This approach is also valuable to the education program.

3. Goals and Objectives

The goals of hospice are to:

- control pain and relieve other symptoms,

- provide emotional support in an informal, home-like atmosphere,

- view the patient as a whole person and not as a disease,

- consider the unit of care to be both the patient and the family constellation,

- focus on the special needs of patient and family and help them to live effectively as they experience the stresses of dying, death, grief and bereavement,

- assist the patient and family to live in character, and to grow during the process of the illness,

- provide continuity of care and not abandon the patient or family -- twenty-four hours a day seven days a week, through home care, inpatient care when appropriate, and after the death through the bereavement period, and

- study and teach improved terminal care.

The primary thrust in hospice care is physical symptom control.* Only when physical pain and other distressing symptoms are controlled can the patient attempt to deal with psychological, social, or spiritual matters. It follows, therefore, that medical direction is a prerequisite of hospice care. Dr. Cicely Saunders (St. Christopher's Hospice, London, England) insists that a hospice be viewed not as a "death house" but as a caring facility with excellent medical care in pain and symptom control, skilled nursing care and attention to detail, and continuity of care for patient and family until the death, with care of the family continuing thereafter.

An important aspect of hospice is described clearly in the preamble of the "Assumptions and Principles Underlying Standards of Terminal Care" developed by the International Work Group on Death, Dying and Bereavement and quoted by Foster:**

> "There are two complementary systems of treatment, which may often overlap. One system is concerned with eliminating a curable disease and the other with relieving the symptoms resulting from the relentless progress of an incurable illness. There must be openness, interchange, and overlap between the two systems so that the patient receives continuous appropriate care. The patient should not be subjected to aggressive treatment that offers no real hope of being effective in curing or controlling the disease and may only cause the patient further distress. Obviously, the clinician must be on the alert for any shifts that may occur in the course of a terminal illness that make the patient a candidate for active treatment again. Patients suffer not only from inappropriate active care but also from inept terminal care."

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* Wilson, D.C., Ajemian, I., and Mount, B.M., "Montreal (1975) - The Royal Victoria Hospital Palliative Care Service" in Davidson, G.(ed.) The Hospice, Development and Administration, Washington, Hemisphere Publishing Co., 1978.

** Foster, Z., "Standards for Hospice Care: Assumptions and Principles", Health and Social Work, 4:1, February 1979, 119-127.

This statement emphasizes the importance of medical direction of hospice care and of the constant vigil that must be maintained to assure continuing appropriateness of hospice for each patient.

4. Hospice Standards

The National Hospice Organization has developed Standards of a Hospice Program of Care , approved by the membership. This document lists twenty-two standards, organized into four categories, which clearly define hospice care. They are summarized in Exhibit 1, following.

EXHIBIT 1

NHO HOSPICE STANDARDS

A. Basic Principle Underlying Hospice Care

1. Appropriate therapy is the goal of hospice care.

B. The Nature of Hospice Care

2. Palliative care is the most appropriate form of care when cure is no longer possible.

3. The goal of palliative care is the prevention of distress from chronic signs and symptoms.

4. Admission to a Hospice Program of care is dependent on patient and family needs and their expressed request for care.

5. Hospice care consists of a blending of professional and non-professional services.

6. Hospice care considers all aspects of the lives of patients and their families as valid areas of therapeutic concern.

7. Hospice care is respectful of all patient and family belief systems, and will employ resources to meet the personal philosophic, moral and religious needs of patients and their families.

8. Hospice care provides continuity of care.

C. The Patient and Family

9. A Hospice care program considers the patient and the family together as the unit of care.

10. The patient's family is considered to be a central part of the Hospice care team.

11. Hospice care programs seek to identify, coordinate, and supervise persons who can give care to patients who do not have a family member available to take on the responsibility of giving care.

12. Hospice care for the family continues into the bereavement period.

National Hospice Organization, Standards of a Hospice Program of Care, 6th Revision, February 1979.

(Exhibit 1, continued)

D. The Hospice Program

13. Hospice care is available 24 hours a day, 7 days a week.

14. Hospice care is provided by an interdisciplinary team.

15. Hospice programs will have structured and informal means of providing support to staff.

16. Hospice programs will be in compliance with the Standards of the National Hospice Organization and the applicable laws and regulations governing the organization and delivery of care to patients and families.

17. The services of the Hospice program are coordinated under a central administration.

18. The optimal control of distressful symptoms is an essential part of a Hospice care program requiring medical, nursing, and other services of the interdisciplinary team.

19. The Hospice care team will have:

    a. a medical director on staff
    b. physicians on staff
    c. a working relationship with the patient's physician.

20. Based on patient's needs and preferences as determining factors in the setting and location for care, a Hospice program provides in patient care and care in the home setting.

21. Education, training, and evaluation of Hospice services is an ongoing activity of a Hospice care program.

22. Accurate and current records are kept on all patients.

5. Differences between Hospice and Conventional Care

The majority of articles and books concerning hospice address in some way the comparison between hospice and conventional health care. A comprehensive listing of philosophical differences between them was developed by Wilson in a document by English and Wilson (1979). This list is presented here with some recent modifications. Wilson has expressed concern that the oversimplification necessary to identify the differences is interpreted literally as a dichotomy. In actual practice, there is increasing evidence of overlapping and blurring of these differences, particularly as the hospice concept becomes better known and has an increasingly significant impact on all health care. This list needs to be approached, therefore, as an oversimplification in the interests of clarity of communication. It is presented in Exhibit 2 following.

Exhibit 2

Conventional	Hospice
(1) Denial of death.	Death in perspective as part of the life cycle.
(2) Cure at all costs. Aggressive investigation, therapeutic intervention. Sustaining all systems and prolonging living.	"The capacity to act does not justify the action." Not shortening life but also not prolonging dying. Reality faced in consideration of appropriate therapy.
(3) Emphasis on the living process. Emphasis on technology and new technological advances. Some radical procedures in terminal cases have been described as "treating the doctor, not the patient".	People-oriented and patient-centered. Emphasis on details of total care. Skilled medical care in relief of symptoms, expert bedside nursing approach.
(4) Emphasis on quantity of life.	Emphasis on quality of remaining life.
(5) Emphasis on defeat. When decision is made that "nothing can be done", case is considered a medical failure, and patient is filled with anxiety, depression and despair.	Emphasis on opportunity. There is always much that can and should be done to relieve pain, other symptoms, distress, fear and isolation. This can be a period of growth for the patient, family and staff.
(6) "Terminal" patients are frequently isolated, away from patients expected to live and from their families, and deserted by their physicians. Nurses take longer to answer these patients' bells.	Presence and companionship characterize relationships. Communication and support emphasized. Inpatient care includes more than normal nursing hours per patient day. Major contribution by volunteers. Families participate in the care. Visiting hours unlimited and children permitted. Family may stay overnight in crisis periods.
(7) "Conspiracy of silence" practiced. Diagnosis, prognosis and discussion of these tend to be withheld.	Patients and families encouraged to share as they wish, to come to terms with reality, to plan the death rituals and the family's future, to proceed with "unfinished business" and participate in anticipatory grief.

English, D.J. and Wilson, D.C., The Hospice Concept, Rockville, ELM Services, Inc., 1979.

	Conventional	Hospice
(8)	Physical systems maintained with intravenous fluids, forced feedings, nasogastric tubes, laboratory examinations and x-rays. Temperature, pulse, respiration, blood pressure taken regularly. Scheduled eating and sleeping times maintained.	In most instances all these are discontinued as unnecessary and not contributing to the comfort of the patient. Primary concerns are comfort, mobility, participation (quality of life). Food type, quantity and frequency gauged to suit the patient's wishes.
(9)	Therapies and life support systems normally continued.	Symptomatic treatment only, such as radiation therapy for reduction in tumor size, nerve blocks for relief of pain, or administration of oxygen to ease breathing but not to prolong life.
(10)	Pain treated with limited amounts of medications on PRN basis. Fear by physicians of psychological dependence, addiction. Goal is treatment, not prevention, of pain.	Major emphasis on pain control. Studies show addiction not a factor in (chronic) pain continually prevented and dose just enough to eliminate pain. Careful and continual titration of amount of narcotic to individual needs, prescribed for administration at regular intervals (based on the serum half-life of the narcotic) around the clock to eliminate pain, while maintaining normal affect. Ease of administration emphasized for patient mobility and independence. Emphasis on relief of side effects of narcotics, especially constipation and nausea.
(11)	Physical pain, depression, and acute anxiety reaction treated directly as separate individual symptoms.	Clinical appreciation of delicate balance between psychological pain, social pain and physical pain.
(12)	Acute care wards, nursing homes, or unattended care at home the alternatives for terminal patients.	Emphasis on patient at home, and dying at home if possible. Maintenance at home supported by home care interdisciplinary team and 24 hour 7 day a week staff availability.

	Conventional	Hospice
(13)	Framentation of care. Little communication between various hospitalizations. Different nursing staff caring for the patient each day. Staff shifted from ward to ward.	Continuity of care. Patient not abandoned whether at home or in hospital. Staff not shifted to other departments. Complicated medical and family problems sorted out by interdisciplinary team with patient and family participating. Family conferences.
(14)	Care is one way -- for the patient. Patient's opinion is not invited.	Participation of patient is encouraged. Staff listen and converse with full attention. Patient contributes to the knowledge and understanding of family and staff.
(15)	Role of the nurse frequently subservient and task oriented, caring for patient.	Nurse role includes decision making in physical and psychological care, and participation in team discussions and caring about patient: "Comprehensive nursing care".
(16)	Little attention directed to treatment of patient's diminishing resources, self image and self confidence as disease and disfigurement progress.	Greatest possible feeling of well-being and self-worth encouraged. Physical, occupational, speech, music, drama and recreational therapies employed.
(17)	Depersonalization. Patients expected to fit into the system and follow regulations.	Emphasis on the patient as a person and a family member. Patients encouraged to express individuality, wear own clothes, maintain own idiosyncracies. Allowed to die as they lived, not according to a predetermined mold.
(18)	Little space or opportunity for patient-patient support systems.	Facilitation of patients helping patients, families helping own patient and also other patients and families.
(19)	Terminal spiritual support relegated to clergy and chaplains, not always skilled in this work.	Consideration of spiritual matters encouraged but not forced. Openness and acceptance of the patients "where they are" rather than "where they should be". All staff participate, not clergy alone (all are team members).

	Conventional	Hospice
(20)	At time of death, patient frequently alone. Body transferred out as quickly as possible.	Family encouraged to be with patient. Staff stay with patient if family member not available. After the death, family may stay with the body, may touch it, may pray together, until comfortable about leaving.
(21)	After the death, all contact with the family ends.	Frequent staff attendance at funeral. Continued support of family through Bereavement Follow-up Program, to facilitate grief work and to identify serious coping problems.
(22)	Structured educational programs in professional technical expertise. Continuing technological research.	Widespread multidisciplinary educational program for professional staff, students and the public in the philosophy and practice of palliative or hospice care. Initial and continuing research and evaluation in patient needs, all aspects of care: medical, social, psychological, spiritual, financial. Also analysis of alternative structures and financial coverage.
(23)	Staff seldom supported or educated in terminal care. Isolated.	Team meetings, staff support systems, and continuing in-service education an important emphasis in maintaining high quality care and reducing staff stress.

The difference is one of approach. Conventional care is directed towards investigation, diagnosis, cure, prolongation of life. Hospice care is aimed at meeting total needs and improving the quality and meaning of the remaining life.

C. U.S. Hospice Organizational Models

The structural groupings of developing hospices in the United States are termed "models". The current wide variety of models appears to represent a transitional stage in hospice program development, and is apparently unique to this country. For simplification here, organizational structures of existing hospice programs have been divided into two general groups: independent and dependent hospices. For each group, the organizational strengths and problems are outlined.*

1. Independent or Freestanding** Hospices

These independent organizations may provide care directly or may coordinate care provided by others. Those providing direct services may supplement them by contracting for some additional services.

Independent hospices provide home care, and may or may not provide direct inpatient care in a freestanding facility. (Most of those without an inpatient facility consider "home" to be "where the patient is" and provide "home" visits to the patient whether in the patient's home or in a conventional inpatient setting.)

(a) Volunteer Programs

Many independent programs are primarily volunteer organizations. Their catchment areas are frequently county-wide and they often have paid administrative staff, with operating funds obtained from foundation and individual contributions. Independence has been sought by these programs primarily to gain administrative autonomy. Many believe that "true" hospice care can be provided only outside the health care system.

Problems that have characterized independent volunteer programs providing care include staff burnout due to inadequate procedures, policies and staff support, small referral base due to physician and health care system antagonism and lack of quality control, and failure due to inadequate funding or contractual documentation. Eventually, hospice accreditation requirements may severely limit the viability of these volunteer dominated programs.

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* Wilson, D.C. and English, D.J., "Issues in Hospice Administration", in Davidson, Glen W. (ed.), The Hospice: Development and Administration, Second Edition, Washington, D.C., Hemisphere Publishing Corporation, Anticipated 1982.

** The meaning of the term freestanding as used here is that of common hospice usage (an independent, incorporated entity) and differs from the meaning proposed by the American Hospital Association (a facility not physically attached to a main hospital building).

(b) Licensed, Reimbursed Programs

Other programs in this group, however, are non-volunteer programs, which have been licensed as home health agencies (or as other formal structures within the health care system) and are being reimbursed for care to the greatest extent now possible. These are expected to survive and may prosper if they give sufficient attention to both quality of patient care and excellence of administration.

(c) Coordinating Programs

These are independent organizations not providing direct care which contract all direct care to home health agencies and/or hospitals. They themselves provide coordination, trained volunteers, training to the contracted staff, and public education (some of the non-reimbursable hospice activities). A single program may encompass the entire community.

Here contracted staff may not be designated as hospice staff and may in fact allocate a very small percentage of their time to hospice work, thus frequently providing low quality hospice care. A major difficulty in this type of organization is assuring continuity of care among several contracted organizations. Failure, staff burnout and/or inappropriate care frequently result. Programs which contract all of their direct patient care tend to be transitional organizations which will meld into more stable structures.

(d) Friendly Visitors

A fourth type of program in this group may be identified by its advocates: the independent program not providing care, not contracting care, but supplying volunteer "friendly visitors" and patient advocates. Such efforts frequently are helpful in the absence of a hospice, but, by definition of the National Hospice Organization, are not themselves hospices.

2. Dependent* Hospices

These programs have been formed as a part of one or more larger organizations: a hospital, a home health agency, or a consortium of both. Some hospitals with hospice

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* The term dependent does not connote lesser quality but refers to the organizational structure as being dependent or affiliated with another organization.

work full time for the hospice. There may, however, be no full time designated staff, or there may be a combination of both full time and part time staff.

In this structure, the strengths and problems can be more clearly identified. Strengths include the administrative expertise and financial stability of the parent organization and a potentially large physician referral base, since the program operates within the established health care system. If the parent organization is a large hospital, additional strengths include the availability through the parent organization of an interdisciplinary breadth of personnel and already-established training and support systems. Problems include loss of autonomy (the continued existence of program decisions, by virtue of the program's position in the organizational structure, being made by others in the hospital's administration), frequent inability to admit patients unable to pay, and, in some cases, care little different from conventional care.

The motivations of hospitals, nursing homes and home health agencies in introducing hospice programs may be quite different from those of independent hospices. Examples for the trainer of the variety of possible additional motivations by such institutions include: to fill beds, to compete with other institutions, to increase the number of home care visits, and/or to reach other institutional goals. For these programs to succeed their primary objectives need to include team function, quality of care and quality of life for the patient and family.

D. Hospice Staffing and Staff Characteristics

Hospice staff members and staffing patterns have a significant impact on the program's development. Staff selection and orientation, personnel policies and procedures, staffing patterns, and staff support are major issues in hospices and are important to training. Also, hospice staff characteristics, although not yet well researched, significantly affect the progress of the training.

1. Staff Membership

As stated in the hospice Standards, hospice care is provided by an interdisciplinary team providing humanistic patient care. Members of the care team or teams may include the following disciplines:

Medical director
Other hospice physicians
Primary physicians
Head nurse or home care coordinator
Nurses

Nurse aides/assistants
Social workers
Chaplains/clergy
Dietician/nutritionist
Therapists (PT, OT, RT, and others)
Volunteers
Pharmacologist
Administrative staff
Homemakers (home care component)

2. Staff-Patient Ratios

Some guidelines have been established for nurse-patient ratios, although these are not consistent among all hospices:*

- In inpatient hospice units, the nurse-patient ratio is higher than on medical/surgical floors, and lower than in intensive care units. The higher ratio is required because of the dependency of the patients, the time required (in addition to regular nursing duties) for meeting the psychosocial and other needs of patients and also of their families. If bereavement care is included in the duties of nurses, additional time needs to be allocated for this. If a large number of volunteers participate actively in the care, perhaps less nursing time is required.

- In home care, the ratio has been estimated at ten patients per nurse, but this number varies considerably (from three to eighteen have been recorded) depending on the age of the hospice, the attention directed to reimbursable care, the condition of the patients, the distances to be travelled, and the amount of record keeping to be performed by nurses.

- In bereavement care, nurses may or may not participate. If they do, they tend to fit it intc their regular schedules or do it on their own time. In many hospices, bereavement follow-up is performed by volunteers, under the direction of the social worker and with the participation of chaplains, clergy, counselors and/or psychiatrists.

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* Report to the Congress of the United States by the Comptroller General, Hospice Care - A Growing Concept in the United States, General Accounting Office HRD-79-50, March 6, 1979, and English, D.J. and Wilson, D.C., The Development of Guidelines for the HSA Review and Planning of Hospice Programs, Rockville, MD, ELM Services, Inc., 1979.

3. Personnel Policies

It is important to know the formal organization and job descriptions of staff positions in hospices to understand some of the rules under which the staff operate. These need to address the hospice emphasis on "role blurring".

Frequently a hospice issue is the hours of work of the patient care staff. Staff members feel that because of the stressful nature of the work, the hours should be shorter than in other health care organizations and/or extra paid time-off should be permitted. No overall hospice policies or standards have yet been established.

Salary levels and fringe benefits of hospice staff tend to be the same as in other health care organizations or lower. Problems arise when hospices which contract all or some of the care find there are major differences in salary levels between contracting organizations or between these and the hospice.

4. Staff Selection and Characteristics

Criteria for selection of hospice staff and volunteers have been developed but are not yet consistent among all hospices. Once these criteria are established by a hospice, recruitment and selection procedures should follow those of good business practice everywhere. Volunteer selection should be performed according to the same stringent procedures, regardless of the fact that volunteer services are provided without financial compensation.

Overall staff characteristics frequently include the following (with additional requirements for some disciplines, and with certain variations identified for home care or inpatient care staff):

- Able and willing to work as part of an interdisciplinary team,
- Motivated to work with the dying and bereaved,
- Sensitive to the needs of patients and families,
- People-oriented, rather than technically-oriented,
- Emotionally mature and confident,
- Flexible, open to new ideas and methods, and willing to be trained,
- Stable home life and significant outside interests,

- Some past life-threatening experience, but no recent personal bereavement (within one year), and
- Able to cope with the stress of continual multiple losses (deaths).

In one study* willingness and ability to work as a team member was mentioned twice as frequently by hospices as was the next most frequently mentioned characteristic. Other frequently mentioned characteristics included: maturity, stability, motivation, independence (particularly in home care), and creativity. This study identified three major problems in selecting staff based on the stated criteria:

- Few if any applicants meeting all criteria are likely to be found. Some weighing of criteria is needed.
- Judging applicants in terms of criteria such as maturity and integrity is difficult, given existing measurement techniques. A method needs to be developed.
- The real meaning of words - such as team, new ideas and methods, training, stress - must be understood clearly by both the employer and applicant. The employment interview and reference follow-up, therefore, must be carefully planned and structured.

5. Staff Support

Even though the required characteristics stated above include ability to cope with the stress of hospice work, hospice staff members almost universally need additional support structures to continue in the work and to prevent high turnover and "burnout". It appears that those attracted to hospice tend to have a high need to serve** and for them hospice offers almost unlimited opportunities to serve. Also, hospices encourage staff involvement with patients and families beyond conventional professional guidelines***. These factors make it difficult for staff to set limits and to structure their emotional involvement for long term hospice activity.

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* Wilson, D.C., English, D.J., and Research Staff of the ELM Institute, An Assessment of the Existing Staffing Patterns and Personnel Required in a Hospice to Deliver Interdisciplinary Patient Care and the Problems Related to Delivering Humanistic Care to Hospice Patients, prepared under contract No. 232-79-0082 for the Health Resources Administration, U.S. Department of Health and Human Services, July 1980.

** Beszterczey, A., "Staff Stress in a Newly Developed Palliative Care Service", Canadian Psychiatric Association Journal, 22: 347-353, 1977.

*** Lack, S.A. and Buckingham, R.W., III, First American Hospice: Three Years of Home Care, New Haven, CT, Hospice, Inc., 1978.

The support systems common to most established hospices include:

- Staff support meetings, held regularly, (weekly or less frequently), led by a psychiatrist or counselor, for direct patient care staff and in some cases for all hospice staff, for the purpose of raising problems faced in patient and family care. These are meant to be work related, not self-revealing sensitivity sessions; they are intended to be unstructured, with participant initiated topics discussed, to provide an outlet for the expression of stress in a positive environment.

- Educational meetings and resources, including orientation, inservice education, library resources, special guest speakers, and special educational events outside the hospice. Both the information learned and the group environment of educational meetings contribute to staff support.

- Staff support persons (frequently physicians, social workers and chaplains).

Other support systems include special time off for grieving or stress relief, and staff social events.

E. Unique Features of Hospice

Although the hospice concept and hospice standards designate both an interdisciplinary team approach to care and the provision of humanistic patient care of both patient and family, it cannot be assumed therefore that training in these areas is unnecessary or easy. Some unique features of current hospices in fact make such training not only essential but also quite difficult. These features include those summarized below.

1. Quality of Staff Selection and Training

In existing hospices staff are not always selected, oriented and trained according to the state-of-the-art knowledge in these areas, even if this knowledge is available. From the executive director on down, staff are frequently employed because they are available and committed or are willing to accept the salary offered. Some staff may be meeting their own personal needs by working in hospices, which may affect the quality of their work. Others may be highly skilled professionals technically but lack a team and humanistic approach.

Frequently, too, people with the required qualifications do not apply, perhaps in part because the positions were not widely advertised. For positions such as the medical director or chaplain, if the work is expected to be contributed without charge, hospices may have little or no choice but to accept whoever offers.

As noted previously, staff members may be paid or volunteer, full time or part time, employees or contracted staff, representing a few or a large number of disciplines.

Orientation and training are not only essential (because of the virtual absence of hospice training elsewhere) but also difficult to design and conduct. This is particularly true if there is no experienced knowledge or advice available or if those planning and conducting the training are themselves inappropriately employed.

The factors here are the newness of hospices in general, their popularity, their lack of funds, and their sense of urgency.

2. Team Composition and Roles

It is frequently difficult to determine the number and composition of the team or teams in a hospice. Because of the common dedication of all staff to the concept - and in some hospices the belief that each contributes equally - all staff and volunteers may be considered to be members of a single team. Such a team may be of unwieldy size, may have incongruent goals, and may never be able to meet together at the same time. In other hospices, the team is a select group, and other staff are members of a "resource pool" outside the team. Or the team may include only one or two professions (nurses and physicians, for example) while other staff are peripheral to it.

Because of the interdisciplinary nature of hospice care, the team composition may change for each patient. More information on hospice team types and composition is provided in Chapter III, Section B. of this monograph.

Within the team, whatever its size and composition, role clarity is conceived as being difficult because of the hospice emphasis on role blurring. Role blurring has special meanings here:

- Hospice provides a variety of skills and personalities; each patient chooses which staff member(s) he or she can relate to best, and the rest of the team supports that staff member in meeting the patient's needs.

- The patient's needs may occur or change at any time; each staff member must be ready to meet the needs as they occur and not postpone this attention until the conventionally proper professional representative can be present.

- Staff members cover for each other through shifts,

days off, etc. and must fill the place of the other as required.

The meaning of patient care team and role blurring in hospices is illustrated by the following example, quoted from Monograph 5.

> (1) Hospice care is a team effort, but not a team with a fixed and constant leader; leadership should evolve upon the one most competent in the major area of focus of the task at hand.
>
> (2) The hospice staff, volunteers, patients and families are not a structured establishment designed after traditional edifices, but are a family, a community - a caring community - of interdependent, caring and needing persons ever in flux - sometimes giving, sometimes receiving, always sharing.

3. Hospice Size and Model

The model of the hospice - whether it is an independent home care program or a hospital-based full component service - will have an impact on the training program plan. Each model has unique features relevant to training. Further complications arise with extremes in program and in staff size.

- In small independent hospices, it may be anticipated that there would be one team to be trained in both sections of the training. This team would include supervisors and supervised. The interrelationships between the individual participants is key to both the training and the progress of the hospice; skill on the part of the trainer is key to maintaining and enhancing these relationships.

- In larger independent single component (home care) hospices, more than one group or team may be identified for training. There may be many choices concerning the personnel to be trained and the number of separate training groupings, if more than one. In such a large group, particularly if the hospice has grown quickly, issues may be expected to include communication between groups as well as between individuals, the relationships between supervisors and supervised, and individual staff member roles.

- In hospices including both home care and inpatient care, particularly those that are part of hospitals, the number, size, and composition of teams and their interrelationships vary considerably and become an issue for the trainer in planning training. In the inpatient component, the additional feature of shift

work adds additional questions of team composition, training timing and number of separate groups to be trained. Care of patients by volunteers during staff training sessions may be a solution in some cases; the participation of volunteers themselves in the training raises an additional issue.

4. Medical Community Support and Physician Role

The quality of care provided by a hospice to its patients and families is affected by and also affects the support it receives from the medical community. Although patients may be referred to the hospice by physicians, family members or the patients themselves, each admission must be approved by the patient's primary physician. The success of the hospice is therefore dependent on the support of the primary physicians in the community. (Those hospices which attempt to operate outside the health care system frequently suffer because of their antagonism to physician involvement.) The anticipated outcomes of the proposed training include increased physician support through improving the care provided. However, planning and conducting the training tends to be difficult if medical community support is an important hospice issue.

Hospices vary in their policies concerning the role of the primary physicians and the role of the hospice medical director and other hospice physicians, if any. Primary physicians tend to want to retain their patients whereas hospice physicians tend to have greater expertise than primary physicians in the care of these patients. In some hospices, hospice physicians provide specialized advice to primary physicians and act as a resource, in others they take over the care of the patients from the primary physicians, or there may be other variations in-between. There are clearly advantages and disadvantages to each of these policies; the training is affected not so much by the policy concerned as by whether or not it is accepted by the medical community.

In addition, however, the composition of the team and the ability of the staff to provide humanistic care may be in part a function of the role of the hospice medical director. If this role is insignificant, the medical director may not even be included as part of the team (i.e., "team" as an organization development conceptualization rather than an NHO defined "team") to be trained; the impact of the training, then, may be a function of the ability of the hospice to incorporate the primary physicians into the team (or teams). If, however, the role of the hospice medical director is a significant one both as a leader in the hospice and as a respected member of the medical community, and if the medical director is prepared to be a team player, the impact of the training may be enhanced.

Training may be particularly difficult in hospices where the physician roles are not clear or are misunderstood.

Training in such hospices may need to be postponed until these matters are clarified, particularly in newly formed hospices, or the training may be essential to the clarification in other hospices.

5. Relationship with the Health Care System

The unique nature of some hospices which attempt to operate outside the health care system has been referred to above in terms of the issues of physician referrals and role. Other issues for these hospices include financial viability and, for many with volunteer management and staff, the level of administrative expertise and the consistency of care provided by a large pool of part time volunteer care providers.

Hospices which operate within the health care system face other issues. The hospice concept does not fit readily within this system, particularly in the non-medical aspects of patient care and in the inclusion of the family as part of the unit of care both before and after the patient's death. Also, hospices cut across established departmental lines (medicine, surgery, OB/GYN, etc.), drawing patients from many departments and utilizing many disciplines in their care. The organizational position of the hospice within the health care system is important here as it affects the hospice's ability to select staff, to attract the many disciplines needed, to develop a team approach, to select patients, and to provide humanistic care. The hospice emphasis on home care, too, does not appear to fit the health care system in many ways. Clearly the team's concept of its role in relation to the health care system affects the level of staff stress, the function of the team, the provision of humanistic patient care, and the impact of training in these areas.

6. Reimbursement

The difficulties hospices face in operating in relation to the health care system are reflected in their difficulties in obtaining adequate reimbursement for their activities, since reimbursement regulations are based on today's health care system. For example,

- The hospice concept stipulates that hospice-eligible patients be admitted regardless of their ability to pay, yet hospices cannot continue to function without funds.

- Hospice care includes bereavement follow-up, yet this is not a reimbursable activity.

- Hospice patient care staff members try to spend as much time as is needed to meet patient and family needs, yet reimbursement rates, particularly in home care, are based on number of visits and not hours of work.

- Hospices encourage role blurring, based on patient/family need, yet reimbursement regulations do not allow for, say, nurses performing social work functions.

Because of mismatches such as these, hospices which provide care according to the hospice concept tend to have major financial problems. Those which are economically viable may have relinquished certain principles of the hospice concept. In both situations staff stress is affected, and in both the proposed training is probably appropriate. However, in the former hospices may not be in a position to pay a trainer; in the latter the issues relevant to training will undoubtedly include goal prioritization and communication between the hospice and outside organizations.

The struggle in the minds of both management and staff members of hospices of all models seems to center around financial viability versus quality of patient and family care. Although reimbursement regulations may be modified in favor of hospice care eventually, hospices can be expected to continue to face these reimbursement issues for a number of years to come.

Since the trainer not only conducts the training sessions but also participates in the identification of issues and the development of the training program design, some of the alternative training structures and training program participants in hospices are discussed in the following chapter. This information is provided both here and in Monograph 1, Guide for Hospices, since it is anticipated that the development of the training program plan will be a joint hospice/trainer endeavor.

CHAPTER III. TRAINING PROGRAM ALTERNATIVES

There are no unalterable rules concerning the structure, length, frequency or timing of the training sessions nor the complement of staff to be trained. However, some comments and suggestions are presented, based on ELM's hospice training experience. (These comments are also included in Monograph 1, Guide for Hospices.)

A. Training Program Structure

Although this series of monographs describes a training structure that has proved successful in the past, it leaves open to the trainer and the hospice a variety of alternatives

- In the recommended program, the structure is made up as follows: interdisciplinary team training precedes humanistic patient care training, interdisciplinary team training opens with a session on goals, and humanistic patient care training opens with a session on definitions and applications, although, within each of the two sections of the training program (Monographs 4 and 5), a number of alternatives in session organization or sequence are discussed. This overall structure is recommended for a number of reasons, including the assumption of an increased comfort level on the part of the participants as the training proceeds so that participants are ready for each session as it occurs. However, in hospices where the comfort level of the group is already high and/or the staff's major concern is the humanistic patient care section, it may be wise to modify the recommended structural sequence. Similarly, it may be possible for the two sections to be provided concurrently, or partially overlapped.

- The number and length of the sessions in each section, described in Monographs 4 and 5, are based both on those needed in hospices where training has been conducted and on those recommended in the literature. Again, these may be modified. However, careful consideration needs to be given to this question by both the hospice and the trainer to ensure that a sufficient number of sessions of sufficient length are provided for the issues to be addressed and for the training process to be effective.

- The frequency of sessions is variable, and has not been consistent among those already trained. Sessions may be held weekly, twice a week, every two weeks, or full time for several days; the suggestions of the trainer are important here, particularly after the data collection activity, in planning the training schedule.

- The elapsed time between the interdisciplinary team training and the humanistic patient care training, if held sequentially, may vary from none to several months

without apparent negative effects. It is postulated that a short period between the two allows the participants to integrate their new skills and approaches before beginning the next section.

B. Training Program Participants

The selection of participants in the training presents many alternatives. For example, the participants in each of the two sections need not be the same, and, in the interdisciplinary team training, more than one team may be trained, either separately or together.

1. Identification of Teams for Interdisciplinary Team Training

The many models and levels of development of hospices make it difficult to specify hospice teams clearly. The following differentiation may provide a useful general approach:

- Management Team. This term identifies the hospice administration, which may or may not operate as a management team, but which may develop into a management team through the training process. Membership usually includes the director, the administrator (if a different person), and the supervisors, usually including the medical director, nursing director (for all nursing or for each of inpatient and home care), social work and/or bereavement director, chaplaincy coordinator, volunteer coordinator, education coordinator, etc.

- Core Team. This team, most frequently found in smaller hospices, includes the management team plus those primarily responsible for patient care (usually the nurses). It may also include the hospice secretary.

- Patient Care Team or Teams. Depending on the size and number of components of the hospice, these teams may either be defined as the small groups which may change with each patient depending on that patient's needs, or may be component teams, including all those participating in each component of care provided: home care, inpatient care (may be split into shift teams), and bereavement care. Membership in one or more patient care teams usually includes all patient care staff including those listed above plus aides, therapists, nutritionists, etc., but not the hospice director. Frequently, volunteers are represented by volunteer leaders for each component rather than all volunteers belonging. Similarly, clergy may be represented by the hospice chaplain coordinator or may all be included. Individual patient care teams consist of specified groupings of these individuals.

2. Designation of Interdisciplinary Team Training Participants

It is possible for all staff to participate in the training, in one group (if of manageable size) or in several groups. The group to be trained, however, should be a group which considers itself a team directed toward accomplishing a particular task which requires coordination of team members. It also needs to include three or more disciplines for interdisciplinary team function in task performance. It should be noted that it is valuable for the group itself to be involved in determining its membership.

Factors which influence the choice of training participants include the following:

- Participation should be voluntary, with the condition that, once they agree, the participants will continue to attend all sessions.
- The objectives of the training, and the identification of training needs, help identify those who should participate.
- Scheduling of time (particularly inpatient shifts) may prevent some appropriate participation unless alternative care staff members are supplied.
- Availability of funds for alternative care staff, and the level of reimbursement of regular paid staff for training time, may limit the number or levels of staff able to participate.
- Choices may need to be made for large groups (such as volunteers) or rotating discipline representatives (such as chaplains or physicians).
- Special decisions may be required for individual problems, such as for particularly disruptive individuals, management favorites, staff members soon to resign, and those peripheral to the primary tasks of the team.

Although the trainer needs to have a clear view of the group or groups to be trained, based on experience and the issues identified from the data collection, he or she must also take into account the recommendations of the hospice administration in the choice of participants.

3. Designation of Humanistic Patient Care Participants

While interdisciplinary team training clearly emphasizes team function and therefore requires team participation, humanistic patient care training may be enhanced by a more liberal interpretation of the patient care provider. All individuals who have direct contact with patients and their

families, as well as those who supervise these individuals, may benefit from training in the humanistic approach. Although appropriate group size for effective training may limit those participating, and although the same factors of time and funding affect this as well as team training, consideration should be given to including the following personnel in humanistic patient care training:

- Patient care staff (physicians, nurses, aides, homemakers, social workers, therapists, clergy, nutritionists, etc.),
- Hospice secretarial staff and insurance/accounting staff who have direct contact with patients and families, if only by telephone,
- Administration, whose administrative and fiscal duties are affected by the humanistic approach to patients and families,
- Local clergy, and
- Volunteers, particularly those participating regularly and frequently in patient care.

The recommendations of the trainer should have a major influence on the choice of humanistic patient care training participants and on the size of the group to be trained. The trainer may also be in a position to advise concerning the implications of changes in participants between the two training sections for the particular hospice concerned.

Trainers considering hospice training need to ensure that they possess the knowledge, skills and motivation to assist hospices in designing the training program and in facing and resolving the identified issues through the training program sessions. What the trainer needs and how the trainer operates in a hospice setting are discussed in the following chapter.

CHAPTER IV. HOSPICE TRAINERS: PREREQUISITES AND ROLES

A. Introduction

Both team and humanistic trainers can be expected to be confident of their abilities to train and also to be skilled in selling their services. Hospices, however, have been advised (in Monograph 1) to resist a trainer's ability to convince others and to look at the trainer's knowledge and skills relevant to that hospice's particular concerns. It behooves the trainer also to consider his or her own abilities in relation to the needs of hospices.

This chapter addresses the special qualities, activities, interests and motivations that trainers need to possess or to develop in order to be comfortable in a hospice setting. Also described is the role of the trainer in training hospice staff members in both interdisciplinary team function and humanistic patient care. With this information, a trainer will be better able to choose whether or not hospices are suitable potential clients. The material is arranged under the following headings:

- Hospice Prerequisites,
- Trainer Motivations,
- Role of the Interdisciplinary Team Trainer,
- Role of the Humanistic Patient Care Trainer,
- Role of the Trainer as a Group Leader, and
- Trainer Self Assessment.

B. Hospice Prerequisites

The prerequisites that hospices need to fulfill to consider themselves ready for training are discussed in Monograph 1, Chapter II. In addition, for the training by a particular trainer to be successful, a hospice needs to fit that trainer's style, methodology, and required comfort level. Some criteria for a trainer to judge whether or not a particular hospice is suitable for that trainer are summarized below.

1. The size of the hospice and of the teams to be trained is satisfactory. The staff represents multiple disciplines and attempts to function as a team.

2. Basic staff orientation, development, and inservice education are already in place.

3. The staff members have expressed interest in and a need for training and are willing to experiment with new health care conepts and new learning methods.

4. The hospice provides care in accordance with recognized hospice concepts and standards, including: medical direction, attention to the physical, emotional, social and spiritual needs of the patient and the family, inclusion of the patient and family as team members, and continuation of family care after the death. (See Hospice Standards in Chapter II of this monograph.)

5. The logistics are satisfactory for performance of the training. These include:

   - There is one central control person with whom to negotiate - the "client". There is a clear contract for the work and agreement on limitations.
   - There is access to the personnel needed, including the hospice director, and clear agreement on limitations of access.
   - There is an adequate degree of stability in the organization, including:
     - the organization is sufficiently viable economically to assume its on-going existence, and
     - the staff is sufficiently stable to ensure low turnover during the period of training.

6. The hospice is in a position to undertake the financial commitment for both the cost of the trainer and the cost of staff time for the training sessions.

7. There is a volunteer program and a body of trained volunteers who are willing to commit additional time to participate in the training.

8. The hospice is ready to face the issues and to institute changes resulting from the training.

9. The training objectives can be reached within the framework of the available resources and existing constraints.

C. Trainer Motivations

1. Concern about Death

Some trainers may find it difficult to consider working so closely with the idea of death. Others may be overly anxious to do so for their own personal reasons. Since either extreme may well be detrimental to the success of the training, trainers are urged to consider carefully their motivations in working in hospice settings.

2. Research and Confidentiality

Another trainer motivation may be to use the experience in hospice training to further their own research, writing or teaching. Trainers are urged to understand and acknowledge the confidential nature of this training - both the data collection and the formal training sessions. None of this information, written or verbal, and none of their experiences and impressions are to be used outside the hospice setting without the written agreement of the hospice director, management and staff.

3. Motivations Needed

Trainers do need to be motivated in certain positive respects, including the following:

- To face their own death or at least to allow themselves to be exposed to issues concerning care of dying people,
- To be open to new issues,
- To accommodate their working methods to new concepts,
- To develop training approaches to fit the hospice realities,
- To design a wide variety of sessions, and
- To adapt training to time-limited sessions on a periodic basis.

D. Role of the Interdisciplinary Team Trainer

The focus of interdisciplinary team training is to improve the effectiveness and efficiency of hospice teams. The intended role of the trainer is to facilitate learning and to encourage team members to explore how they may function more interdependently. As a result, it is anticipated that team members will provide more responsive and comprehensive care to patients and families and more support for each other.

1. Trainer Role as Facilitator

The role of the trainer is that of facilitator, that is, one who serves the group, concerned more with process than content. It is not the role of the trainer to provide solutions to issues but rather to assist the group in reaching consensus on the solutions it has developed.

As facilitator, the interdisciplinary team trainer assists the team or teams to work through sessions on goals, roles,

structure and procedures (see Monograph 4), and specifically to:

- Reach consensus on the mission of the organization, identification of personal goals, resolution of goal conflicts, and prioritization of goals to achieve the organization's mission,
- Identify, clarify, and negotiate individual roles represented within the team,
- Identify constraints within the organization's structure which have an impact on personal/team effectiveness, and develop problem solving strategies,
- Review critically the team's and the organization's procedures and norms, and develop clearly participatory procedures for more efficient and effective decision making, and
- Become more cohesive and more supportive of its members.

2. Trainer Responsibilities and Activities

Specific responsibilities and activities of the trainer may include the following:

- To assess team function and diagnose blockages to effective collaboration,
- To create an open, problem solving climate with trust and support among members,
- To increase the level of commitment and sense of responsibility for tasks,
- To assist in the identification of team issues and in the development of team building objectives (see Monographs 3 and 4),
- To provide impartial feedback on team performance and process,
- To assist in the identification and resolution of intragroup problems,
- To provide resources and skills not available within the group, and
- To develop skills within the team, including skills in self-monitoring techniques.

E. Role of the Humanistic Patient Care Trainer

The focus of humanistic patient care training is to heighten awareness, increase knowledge, and improve the skills of hospice staff members in their relationships to patients, to family members, to each other, and to staff members of other organizations. The training is intended to facilitate learning, understanding, and communication. Training sessions are not intended to afford an opportunity for in-depth introspective exploration of values or to become sensitivity sessions. The purpose of the training is to enable staff members to provide improved communication with those outside the organization, and more understanding and support of each other.

1. Trainer Role as Facilitator

The role of the trainer is that of facilitator, that is, one who serves the group, concerned more with process than content. It is not the role of the trainer to provide solutions to issues but rather to assist the group to reach consensus on the solutions it has developed.

As facilitator, the humanistic patient care trainer is expected to:

- Raise appropriate issues or questions for participants, and encourage the exploration of their own values,
- Create an environment of trust and sharing in which opportunities for growth are increased,
- Facilitate the identification of needed skills in building interpersonal relationships and provide instruction in these skills,
- Encourage the development of group self-monitoring mechanisms, and
- Discourage the group from moving into highly sensitive intrapersonal or interpersonal areas which might result in psychological or emotional damage to individuals.

2. Trainer Responsibilities and Activities

Specific responsibilities and activities of the trainer may include the following:

- To become as knowledgeable as possible about the hospice organization and group to be trained (see Chapter II),

- To identify, with the group's assistance, the issues to be addressed in humanistic training (see Monographs 3 and 5),

- To research available training materials, and to select appropriate sections for use, identifying and securing additional trainer(s) for areas requiring special expertise,

- To provide any additional resource persons or alternate trainers with information about the hospice, its staff and the intent of training program; and to guide them in the preparation of their topic area(s).

- To provide substantive information in the identified "knowledge areas", or to arrange for others to do so,

- To provide skills or resources not sufficiently developed within the group and to assist in the development of these skills or resources,

- To assist in the identification of blockages to effective humanistic patient care and to assist in the development of strategies and skills to work through these blockages, and

- To act as the responsible resource person for any key questions which are not dealt with sufficiently in the training sessions because of lack of time or the trainer's limited knowledge in the subject area.

It expressly is not the role of the trainer to provide therapy or to facilitate a sensitivity or T-group. Such exploration of highly sensitive areas could result in dysfunction or pain of an individual or of the group.

F. Role of the Trainer as Group Leader

Any trainer conducting hospice training sessions may be wise to review carefully the functions of group leadership. Sampson and Marthas have developed a useful summary of the various types of leader activity in groups, identifying for each type of leader activity its purpose in group development and its effect on group members. This summary is shown in Exhibit 3, following. The choice of leader activity at each point in each group session requires experience and skill on the part of the trainer.

EXHIBIT 3

Group Leadership

Leader Activity	Purpose of Activity
Supporting	Provides supportive climate for expressing ideas and opinions, including unpopular or unusual points of view.
	Facilitates members continuing with their ongoing behavior.
	Helps reinforce positive forms of behavior.
	Creates a climate in which silent members may feel secure enough to participate.
Confronting	Aids in growth and development; helps unfreeze members from being stuck in one mode of functioning.
	Helps reduce some forms of disruptive behavior.
	Helps members deal more openly and directly with each other.
Advising & Suggesting	Shares expertise, offers new perspectives.
	Helps focus group on its task and goals.
Summarizing	Helps keep group on its task by reviewing past actions and by setting agenda for future sessions.
	Brings to focus still unresolved issues.
	Organizes past in ways that help clarify; brings into focus themes and patterns of interaction.
Clarifying	Helps reduce distortion in communication.

Sampson, E. and Marthas, M., Group Process for the Health Professions, Second Edition, New York, John Wiley & Sons, 1981, p. 258.

Leader Activity	Purpose of Activity
	Facilitates focus on substantive issues rather than allowing members to be side-tracked into misunderstandings.
Probing & Questioning	Helps expand a point that may have been left incomplete.
	Gets at more extensive and wider range of information.
	Invites members to explore their ideas in greater detail.
Repeating, Paraphrasing, & Highlighting	Helps members continue with their ongoing behavior; invites further exploration and examination of what is being said.
	Clarifies and helps focus on the specific, important, or key aspect of a communication.
	Sharpens members' understanding of what is being said or done.
Reflecting: Feelings	Orients members to the feelings that may lie behind what is being said or done.
	Helps members deal with issues they might otherwise avoid or miss.
Reflecting: Behavior	Gives members the opportunity to see how their behavior appears to others and to see and evaluate its consequences.
	Helps members to understand others' perceptions and responses to them.
Interpreting & Analyzing	Renders behavior meaningful by locating it in a larger context in which a causal explanation is provided.
	Helps members understand both the likely bases of their behavior and its meaning.
	Summarizes a pattern of behavior and provides a useful way of examining it through the insights gained.

Leader Activity	Purpose of Activity
Listening	Provides an attentive and responsive audience for those who participate. Models a helpful way for members to relate to one another; gives a feeling of sharing and mutual concern. Helps members sharpen their own ideas and thinking as they realize that indeed others are listening and concerned about what they are saying.

G. Trainer Self Assessment

Guidelines have previously been identified to assist hospices in the selection of appropriate trainers (see Monograph 1, Chapter III). However, it behooves each trainer to assess his or her own qualifications and self preparedness for this work, particularly in the area of group process skills.

Although both sections of the training require many similar qualifications - particularly group process skills - the trainer self assessment is described separately for each, below.

1. Interdisciplinary Team Trainer Self-Assessment

Each prospective interdisciplinary team trainer is urged to ask himself or herself the following questions:

- Do you have a real interest in and respect for the hospice's concerns?
- Are you able to listen actively to both verbal and non-verbal messages in a non-evaluative fashion?
- Are you more interested and better trained in group process than in individual growth?
- Can you observe the dynamics among group members and deduce their impact on team cohesion and function?
- Are you able to serve as a mirror to the group to enable members to be more clearly aware of their own behavior?
- Does your own repertoire of skills include sufficient activities and exercises to enable the group to improve team performance?
- Are you able to provide honest, clear and timely feedback to participants in group process situations?
- Do you have a clear image of yourself as a change agent? Are you sufficiently aware of yourself, knowledgeable about communication theory, and experienced in consultation process and roles to meet the needs of the hospice?
- Do you possess sufficient knowledge in the areas of organization theory, diagnostic and motivational techniques, group process and problem-solving theories, and program evaluation, to meet the needs of the hospice and the training in these areas?

2. Humanistic Patient Care Trainer Self-Assessment

Each prospective humanistic patient care trainer is urged to ask himself or herself the following questions:

- Are you aware of your own personal feelings and intrapersonal processes?
- Are you aware of interpersonal processes?
- Do you have sufficient self reliance to preclude your being manipulated by the members?
- Do you have a sufficient empathy and positive regard for the staff members of the hospice, and will there be congruence in interacting with them?
- Are you consistently sensitive to cultural and spiritual influences on individuals and groups?
- Have you had sufficient experience that your present personal demeanor is calm, accepting, confident, and not easily shaken?
- Do you have any strong personal bias or philosophy which might hamper your ability to facilitate training in this environment?
- Do you have any unresolved personal problems or issues which might reduce your effectiveness in a hospice environment?
- Do you have a personally therapeutic interest in hospices (for example, are you presently interested in exploring issues related to your own death; are you, as one potential trainer stated, "really into death")?

3. Self Assessment Analysis

Even the most knowledgeable, experienced and self confident trainers may find difficulties in responding to the above sometimes searching questions. (To benefit hospice training the responses should be: positive to the team questions; positive for the first six and negative for the last three humanistic questions). A potential trainer may feel that too much emphasis has been placed on the quality of the trainer in this monograph, and that, considering the problems hospices currently face and considering their early stage of development, the contributions of any trainer would benefit them. However, the team and humanistic training that has already been undertaken in hospices has shown clearly that an inappropriate or inadequately prepared trainer may exacerbate rather than relieve the stresses and difficulties in today's hospices.

Information and recommendations concerning trainers, hospices and their relationships, based on ELM's hospice training experience, may be found in the next chapter and in certain sections of Monographs 3, 4, and 5. These may enable the trainer to benefit from this experience.

CHAPTER V. SUGGESTIONS FROM HOSPICE TRAINING EXPERIENCE

Most hospices are already providing humanistic patient care using an interdisciplinary team approach before the trainer enters the hospice setting. It is the purpose of the training program and the role of the outside trainer to improve interdisciplinary team function and humanistic patient care provision. It is important for the trainer to acknowledge the progress hospices have already made in these areas prior to the training, and to identify issues which, when resolved through the training, will have an impact in these areas and may also reduce the stress and increase the efficiency and effectiveness of the staff members. Clearly the goals of the training are congruent with the goals of the hospice.

ELM's experience in hospices and in training hospice staff members in interdisciplinary team function and humanistic patient care has provided some conclusions concerning both trainers and hospices. ELM recognizes that this data is based on limited experience, and hopes that the process and outcomes of future training experience in hospices will contribute useful information for later editions of these monographs.

A. Experience Relative to Trainers

During ELM's hospice training experience, a number of potential trainers were interviewed and considered. There were some who were more qualified than others, some whose motives and styles seemed more appropriate than others, and some whose interest in hospices and hospice staff members was considerably greater than others. Those judged either inappropriate or not sufficiently qualified included the following:

- A bright young lecturer in an academic setting who felt he could quite easily find the information he needed in the library and prepare a paper to read to the group.

- A health care trainer who believed her role was to assist individuals in coping with the hostile environment around them and to adapt to their work climate, rather than seeing individuals as being change agents within their groups.

- An experienced trainer who discussed theory in a way that was over the heads of the group members, and appeared unable or unwilling to make the information clear and meaningful to them.

- A health psychologist, experienced in working with terminally ill patients, who saw the impact of groups on people but did not visualize people as the fabric of groups.

- An experienced trainer who had no knowledge of the health care field and who felt there would be no differences between training teams of firemen and teams of hospice caregivers.

- An expert in hospice care who addressed all his remarks to the members of only one of the disciplines represented in the group.

- A nationally known trainer who seemed to be more interested in describing her own success to the group than in assisting the group to become successful.

Such influences have led ELM to conclude that an appropriate trainer needs to be knowledgeable about health care provision, the disciplines involved (physicians, nurses, social workers, etc.) and their conventional relationships, to appreciate the inherent stress in their contrasting roles, to understand group process enough to be comfortable performing a facilitative role in groups, and to be sufficiently self assured not to let his or her own ego get in the way of the group's progress. The trainer also needs to understand organization theory and training program design in order to help set up the best "custom-built" program to meet each hospice's needs. The trainer, to be effective, must have positive regard for and build good working relationships with the hospice's management, administration and staff.

The appropriate trainer, once identified, can benefit from other results of ELM's training experience in hospices.

B. Experience Relative to Hospices

In preparing for training in a hospice, and, in particular, in negotiating the trainer role with the hospice administration, the trainer needs to be aware of some problem areas. Hospice training experience has identified some concerns and questions which trainers would be well advised to keep in mind, particularly during the negotiation and planning periods and in the early training sessions:

- The hospice may not yet be ready for the training; the prerequisites listed in Monograph 1 may be only partially fulfilled. The trainer should assist the hospice in determining whether or not the unfulfilled prerequisites will nulify the benefits of training, and therefore whether or not the training should in fact proceed. In some situations, it may be advisable for the trainer to postpone the training until certain organizational or administrative problems are resolved.

- For the training to be successful, the hospice management and administration need to view it as essential to the effectiveness and efficiency of the hospice in providing high quality, sensitive patient and family care, and not as a "fringe benefit" for staff members. If the hospice considers the training to be a "fringe", or to be research rather than essential staff development, the trainer may need to address and alter these impressions before the training can proceed.

- Participation by staff members in the training program should be voluntary. However, problems arise if key team members do not agree to participate. The trainer and the hospice should then consider whether the absence of those refusing will have a major impact on the training and on the future functioning of the group, particularly on team function. If, for example, the medical director, who is a part time hospice staff member, is unwilling to invest the time in the training, a decision may need to be made prior to the beginning of the training as to whether or not this medical director is, in fact, a team member. The trainer may need to hold special meetings with the medical director, the hospice director, and perhaps the other potential participants, to clarify this situation.

- Hospice staff, individually or as a group, may resist the idea of an outside trainer coming in to the hospice setting to improve group effectiveness. The trainer needs to be ready to face the frequently found attitude of hospice staff members that such a trainer "understands absolutely nothing" about hospices and, further, that "nobody truly understands" their

hospice and their work. The trainer may need to clarify his or her role as facilitating rather than advising, while acknowledging the unique aspects of the hospice philosophy.

- The training session structure, the size and composition of the group being trained, the physical setting of the session, and the approach of the hospice management will influence the interactions of the participants and the value of the training outcomes. The trainer needs to possess the skills necessary to resolve problems in any or all of these areas to ensure the success of the training.

- During both the planning and the training, emphasis needs to be placed on the fact that this training is a developmental activity and takes time. The trainer needs to ensure that change is anticipated and planned for, through ensuring that there is:

  - Involvement in the training and commitment to change by the participants,
  - Support by the hospice management and administration, and
  - An organization structure that permits organizational change, so that changes developed by the group being trained will be integrated and assimilated into the hospice organization.

- The objectivity of the trainer is essential to the successful facilitation of the training, particularly when interpersonal issues are explored and honest feedback is needed. The trainer may need to assure the training participants and the hospice administration of his or her objective and sensitive approach, through both verbal and non-verbal communication on a continuing basis.

- In the training sessions, the participants may well be reluctant to practice self-revealing or confronting behavior, particularly during the opening sessions. It is important for the trainer to establish as quickly as possible an environment of mutual respect and safety. There needs to be assurance that both the trainer and the participants approach each other in a non-threatening, non-evaluative, supporting manner.

- If the group being trained includes both vocal and quiet members and/or both supervisors and supervised, it is important for the trainer to encourage the equal participation of all members within their level of comfort, and not to permit supervisory members to predominate. The participants need to understand the trainer's role and to develop confidence in the trainer to ensure their freedom of participation within this training session.

- In some proposed training sessions, the trainer's role is not only to facilitate but also to provide knowledge or to teach skills. In this role, it is important for

the trainer to be aware of the knowledge and/or skill levels the group has already attained and to add to that. Otherwise, time and money are wasted and the frustration of the participants seeking new knowledge and skills may increase.

- In hospices there are continual changes taking place - in patients and families, staff and volunteers, and the organizations outside the hospice. Changes and adaptations are therefore needed over time in team roles and procedures and in humanistic care provision. It is an additional role of the trainer to encourage and provide the methodology for the participants to continue to monitor, reassess and revise their activities and approaches through the training through time, after the formal trainer-conducted sessions are completed.

The trainer is expected to read carefully not only this monograph but also Monographs 3, 4, and 5, if the trainer is conducting both sections of the training, or certain portions of the training. To assist the trainer in making the best use of these monographs, a guide to their use is included in this monograph, in the following chapter.

CHAPTER VI. GUIDE TO LATER MONOGRAPHS

The purpose of this chapter is to review Monographs 3, 4, and 5, in terms of their usefulness to a skilled trainer in interdisciplinary team function and/or in humanistic patient care.

The benefits to a skilled trainer in reading and using these later monographs include the following:

- All three monographs can be considered as a refresher course in interdisciplinary team training and humanistic patient care training, if this is needed by a trainer:
  - Monograph 3 describes the steps in designing a training program and in obtaining the confirmation of the program by the group to be trained, and
  - Monographs 4 and 5 provide background information and session outlines for the two sections of the training.
- All three provide examples and information concerning hospices, which are particularly useful to trainers who are completely unfamiliar with hospices and who may assume they are little different from other health care organizations. Trainers thus have an opportunity to think through the hospice environment before being faced with its issues:
  - Monograph 3 describes typical problems and issues in current hospices, and
  - Monographs 4 and 5 describe examples of both training topics and issues in hospices for each topic discussed.
- All three offer information and examples from ELM's and others' hospice training experience. Although some trainers may not feel the need for such examples, others may find them useful. The information and advice contained in these documents are the result of a great deal of time and effort on the part of a number of experienced trainers and consultants, and, it is hoped, will save the trainer from expending the same amount of time and effort again:
  - Monograph 3 provides examples of issue statements in feedback reports and advice about possible pitfalls in hospice

data collection and issue prioritization, and

- Monographs 4 and 5 show examples of documents produced during ELM's hospice training experience as well as quotations from the training sessions by both trainers and participants.

- All three provide copies of questionnaires and exercises used in hospice training which may be used (with permission) or modified by a trainer to meet the needs of the hospice staff being trained:

  - Monograph 3 provides copies of data collection questionnaires and some evaluation instruments.
  - Monographs 4 and 5 provide copies of exercises used and/or recommended for use in hospice training.

- Monograph 3 describes the recommended training techniques, the role of alternate trainers and information concerning training leadership. This portion of the monograph supplements information already found in Monograph 2.

- Monograph 3 disusses evaluation of the training, training outcomes, and both hospice evaluation of the trainer and trainer evaluation of the hospice. The methods and suggestions are intended to assist both the hospice and the trainer in evaluating the training. Some of the results of evaluations conducted during ELM's hospice training experience are included. These make possible comparisons of ELM's experience and the experiences of trainers in other hospice settings.

- Monographs 4 and 5 provide lists of issues and training topics related to these issues. These provide the trainer with a range of topics from which to choose in meeting the needs of hospice staff members and hospice teams.

- Monographs 4 and 5 provide recommended reading in preparation for each training session, for both the participants and the trainer. They also list selected references for each topic, to encourage trainers and others to read more widely in the field.

The table of contents of each of the five monographs is listed in the appendix of each monograph. These tables are provided to assist trainers in quickly identifying and locating any sections of special interest. A review of these lists and the information above will enable the trainer to determine which monographs he or she should acquire.

It is suggested that principal trainers provide alternate trainers with the sections of the monographs applicable to their portions of the training. The alternate trainer may be advised the monographs to acquire, or be lent the monographs needed, or be provided with photocopies of the relevant sections.

ELM recognizes that qualified trainers need little information in training techniques, but require as much assistance as possible in becoming knowledgeable about hospice and comfortable in hospice settings. These monographs attempt to fill this need by providing the most up-to-date and the most comprehensive information currently available.

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